The Commonwealth of Massachusetts

Department of Correction Advisory Council

Final Report

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Governor

Kerry Healey
Lieutenant Governor

Edward A. Flynn
Secretary of Public Safety

Scott Harshbarger
Chairman

October 25, 2005

Department of Correction Advisory Council

One Ashburton Place, Room 2133, Boston, Massachusetts 02108

Edward A. Flynn
Secretary, Executive Office of Public Safety
One Ashburton Place, Room 2133
Boston, MA 02108

October 25, 2005

Dear Secretary Flynn:

I am pleased to present to you the final report of the Department of Correction Advisory Council ("Advisory Council"), pursuant to Executive Orders #461 and #468. The charge of the Advisory Council is to monitor and support the implementation of the recommendations contained in the report of the Governor's Commission on Corrections Reform (GCCR) and to provide recommendations to you on female offenders and medical and mental health services in the Department of Correction.

As you recall, the GCCR report contained eighteen recommendations to promote public safety, accountability and fiscal responsibility. The recommendations were developed with the knowledge that the vast majority of state inmates will eventually be released, and yet nearly half of those released will be convicted of a new crime within just three-years. The GCCR called for tough but smart action to break this on-going cycle of crime, victimization and re-incarceration.

You will note that the Advisory Council's overall conclusion, as set forth in our preliminary report of June, 2005, is that the DOC's progress thus far is impressive. We applaud Commissioner Kathleen Dennehy and her staff for using the GCCR report as a roadmap for change, and for making great strides over the past year. While much has been achieved, more work remains. The GCCR report set forth an ambitious, multi-year agenda that called upon a host of external stakeholders to take action as well. To this end, I must emphasize one of our major conclusions: the DOC cannot do it alone. Meaningful change will require action by a multitude of state and local stakeholders. The Executive Office of Public Safety has demonstrated a leadership role in promoting reform, and we encourage you to continue to serve as a catalyst in moving implementation forward.

The enclosed final report also sets forth several key recommendations for improving two complex areas: female offenders and medical and mental health services. We believe these recommendations, which were based on outstanding work by two multi-disciplinary task forces established to thoroughly examine these issues, should be given top priority.

In addition, this report sets forth a 'priority agenda for action' for the DOC as well as state and local stakeholders. We have concluded that, unless these items are addressed, we can not be certain that the DOC's reform efforts will succeed, nor will meaningful progress be made in stemming the crime and violence caused by returning inmates. We believe this agenda should be a top public safety priority, requiring a renewed sense of urgency, attention and collaboration.

Sincerely,
Scott Harshbarger
Chair, Department of Correction Advisory Council

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS

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We would like to acknowledge Leslie Walker and the staff of Massachusetts Correctional Legal Services for their presentation to the Council.

The council is grateful for the many vital contributions of Murphy, Hesse, Toomey and Lehane, LLP.

A major portion of this report was based on the work of the Dedicated Female Offender and the Health and Mental Health Review Panels. The Council is grateful for the thoughtful recommendations brought forth by all of the talented and dedicated individuals who participated in both of the panels. First, we would like to thank the subgroup chairs of the Dedicated Female Offender Review Panel: Senator Karen Spilka; Dr. Judith Kirwan Kelley; MCLS Executive Director Leslie Walker; Representative Kay Khan; and Representative Liz Malia.

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The council would similarly like to acknowledge the outstanding work of the Health and Mental Health Review Panel subgroup chairs: Dr. Alfred DeMaria; Katherine Keough; Dr. David Power; Dr. Anna Karina Mascarenhas; Dr. John Fromson; Assistant Commissioner Michael Boticelli; and Robert Watson.

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We would especially like to express our gratitude to the DOC's Director of Female Offender Services, Michelle Donaher and Associate Commissioner of Re-Entry and Re-integration, Veronica Madden for organizing and overseeing the work of these review panels.

The council would also like to thank all of the Department of Correction staff who were assigned to each of the subgroups: Lynne Bissonnette, Superintendent, MCI Framingham; Rhiana Kohl, Executive Director of Strategic Planning; and all the staff of the Health Services Division:

especially Sue Martin, Director, Peter Heffernan, Acting Director; Lawrence Weiner; Deborah Mendoza-Lochrie; Linda Herman-Gomes; Greg Hughes; and Jeanie Lahousse.

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DEPARTMENT OF CORRECTION ADVISORY COUNCIL
FINAL REPORT

I. INTRODUCTION

This is the final report of the Department of Correction Advisory Council (the "Advisory Council") established by Executive Order of Governor Mitt Romney on September 15, 2004. The Advisory Council is presently comprised of 14 members with broad expertise in many areas including corrections, health services, mental health services, law enforcement, inmate re-entry, government and law, and is chaired by former Attorney General Scott Harshbarger.[1] The Executive Order sets forth the purpose and responsibilities of the Advisory Council, and states, in relevant part that the Advisory Council shall:

> "monitor the implementation of reforms recommended by the Governor's Commission on Corrections Reform; advocate on behalf of continued reforms; and, where appropriate and necessary, propose modifications to the Commission's recommendations in light of changed circumstances. The Council shall also submit recommendations relative to inmate health and mental health services, and issues pertaining to female offenders in the Department's custody."

The Executive Order requires the Advisory Council to submit a preliminary report to the Secretary of Public Safety within 6 months, and a final report on September 15, 2005.[2] Our preliminary report, attached herewith, was submitted to Secretary Edward Flynn on June 17, 2005. Our final report follows this introduction.

The Report of the Governor's Commission on Corrections Reform

As the Executive Order indicates, one of the primary purposes of the Advisory Council is to monitor and support the implementation of the recommendations contained in the report of the Governor's Commission on Corrections Reform (the "GCCR").[3] This

[1] The Executive Order calls for the appointment of an attorney with expertise in prisoner litigation or criminal defense and 2 members of the House of Representatives selected by the Speaker of the House. These appointments were never made although names were submitted for consideration.

[2] The members of the Council were not appointed, except for the Chair, until mid-November, 2004.

[3] On September 4, 2003, Governor Romney and Secretary Edward Flynn formed a special panel to investigate the circumstances and conditions surrounding the death of inmate and former priest John Geoghan. Another inmate was later indicted for his murder. During the early part of this investigation, it became clear that there was a need for a more expansive review of the system, including the DOC's policies and procedures. As a result, on October 17, 2003, Governor Romney established the Governor's Commission on Corrections Reform chaired by former Attorney General Scott Harshbarger. The mandate of this Commission was to conduct a comprehensive review of the Department of Correction, including issues related to governance, operational systems, programs, re-entry, and budget. The GCCR consisted of 15 current and former corrections officials, legislators, community leaders, and criminal justice experts.

report, entitled "***Strengthening Public Safety, Increasing Accountability, and Instituting Fiscal Responsibility in the Department of Correction,***" was issued on June 30, 2004. Based on findings and comments developed in the course of an 8-month review, the Report sets forth 18 specific recommendations for reforming the Department of Correction (the "DOC"), and was intended to serve as a blueprint for change.

The GCCR's report set forth an extensive plan to enhance public safety by reducing the rate of re-offense among inmates who return to our communities. In developing its recommendations, the GCCR conducted wide-ranging research on the DOC and on best practices throughout the country, keeping in mind at all times budget and fiscal constraints. Moreover, over the course of the GCCR's review, the former Commissioner of the DOC was replaced. The current Commissioner, Kathleen Dennehy, has served in the leadership role over one year, but had only held that position for a few months when the GCCR's report was issued.

The eighteen recommendations of the GCCR report involve establishing a comprehensive re-entry focus, improving accountability for managers, staff, and inmates, ensuring fairness and consistency in policies and practices, and instituting fiscal discipline (see Appendix A). It is important to note, however, that while many of the recommendations were aimed at the DOC, several recommendations involved action by external players, such as other state and local agencies and policy-makers. The DOC has demonstrated a strong commitment to implementing the recommendations that are within its control. We sincerely hope that other necessary and relevant stakeholders will join them in the task of implementing the GCCR's reform agenda and embrace the goals of enhancing public safety and fiscal responsibility. We urge the Governor and EOPS to shoulder this crucial leadership and coordination role.

II. PROGRESS SUMMARY

In the Preliminary Report issued in June, 2005, the Council provided a progress summary of the DOC's efforts to date. In addition, we recommended action to remove several significant barriers to reform that exist. These barriers are not within the control of the DOC, although they greatly impede the DOC's ability to improve re-entry in a fiscally responsible manner.

In terms of the DOC's progress, the council concluded that the DOC had made impressive strides since July, 2004. We commended Commissioner Dennehy and her staff for efforts to implement each of the recommendations of the GCCR report that were within the agency's control. We noted that each recommendation was put on an implementation timeline, and concrete action steps were defined, assigned to responsible parties, and monitored. Training requirements, staffing needs, best practice research and outcomes were also spelled out.

In the Preliminary Report, we requested that the DOC provide periodic updates on 16 performance measures. In response to this request, the DOC submitted a Performance Measure Report to the Council in July 2005 (see Appendix B). We feel strongly that using these performance measures, and other objective data as a means to evaluate progress, is essential. We encourage the DOC to continue to provide these reports so that trends can be identified, and problem-solving strategies developed and implemented.

Our report then commented on the specific progress made in implementing each recommendation in a section-by-section progress report (see Appendix C). Because only a few months have passed since that Preliminary Report was issued, we incorporate those comments herein, but will not re-evaluate the DOC's progress on each recommendation. Rather, we will use this opportunity to comment on the highest priority work that remains to be done, within the DOC and outside of the department, in order to help reduce the crime and violence caused by returning inmates.

III. RECOMMENDATIONS: FEMALE OFFENDERS & HEALTH AND MENTAL HEALTH ISSUES

The Executive Order stipulated that the Advisory Council submit recommendations regarding female offenders in the custody of the Department of Correction, and prison health and mental health services.

In response to that requirement, the Advisory Council and the Department of Correction established two dedicated review panels comprised of external policymakers, stakeholders, Advisory Council members and DOC staff to examine the issues. These panels devoted significant time and effort to studying data and information, conducting site visits, identifying problems, and formulating recommendations. They each produced extensive reports to the Advisory Council, which, when combined, contained over 80 major recommendations for action. The Advisory Council has reviewed the reports and considers their major findings and recommendations to be generally well founded and deserving of critical attention.

After reviewing this work, we have selected several recommendations which we believe to be of the highest priority. In no way is our highlighting priority recommendations intended to detract from the significance of the remaining recommendations. We hope that Commissioner Dennehy will move swiftly to put together a feasibility assessment and implementation plan for each report that should be brought to the future Advisory Council for review and discussion. We also urge the Governor, Secretary and Legislature to carefully examine the remaining recommendations. They merit close attention and consideration by state policy-makers.

Female Offenders

The Dedicated Female Offender Review Panel ("the Panel") first convened in March 2005. The members of the panel were divided into five subgroups which were each asked to consider one or more of the following nine major issues: overcrowding; booking and admissions; gender-specific medical needs; operations; resources and practices; family connections; reentry; treatment; and fiscal support.

Over the next four months the subgroups met bi-weekly, conducted site visits, invited other policymakers and stakeholders to attend meetings, collected documentation and researched best practices. On August 1, 2005, the groups submitted their findings and recommendations.[4] The Advisory Council has concluded that of the 23 major recommendations, two are of the highest priority and should be urgently addressed. In our opinion, addressing these recommendations will alleviate the severe overcrowding at

[4] The Advisory Council would like to acknowledge the many members of the dedicated Female Offender Review Panel who generously volunteered their time to complete comprehensive and detailed reports in only four months. We would also like to thank DOC Commissioner Kathleen Dennehy and members of her staff, especially Michelle Donaher, Superintendent Lynn Bissonette, Rhiana Kohl, and Sue Martin, who devoted innumerable hours to supporting the Panel's work.

MCI-Framingham, which was designed to house a population of 388 women, but currently holds over 600. Effective action on these two recommendations will also allow for implementation of many of the Panel's remaining recommendations, including those that concern access to programs and services, reentry planning, and staffing. Care of offenders is part of DOC's core mission, and overcrowding and inappropriate placements are barriers to the accomplishment of that mission. If these issues are addressed, the Department can be held more accountable for effective change and reform. Therefore, the Advisory Council recommends, first, that pre-trial detainees and inmates with county sentences be removed from MCI-Framingham and, second, that civilly committed women also be removed.

Recommendation #1 (female offenders): ***Pre-Trial Detainees and Those Sentenced to County Facilities Should be Housed in Their Respective Counties, Not at MCI-Framingham***

The inclusion of pre-trial women and those sentenced to county facilities contributes significantly to overcrowding at MCI-Framingham. The Panel observed that nearly 67% of the population admitted annually to the facility consists of either pre-trial detainees or those serving county sentences of less than 2 1/2 years.[5] In addition, the Panel noted that the combination of female county inmates who serve significantly shorter sentences and state-sentenced females creates obvious major operational, fiscal and ethical challenges. Specifically, it is difficult for the DOC to house inmates safely and efficiently in an overcrowded environment and provide appropriate programming when the inmates have such widely disparate needs and issues. Furthermore, there are cost considerations. It generally costs approximately $10,000.00 more per year to house inmates in a medium/maximum security facility like MCI-Framingham than at county facilities. Finally, there is a lack of parity between male and female inmates because the women at MCI-Framingham are generally more geographically removed from their families, attorneys and re-entry resources than their male counterparts. Therefore, women confront more significant barriers to effective legal counsel and maintaining family and community connections.

In order to implement this recommendation, the Advisory Council suggests that pre-trial detainees at MCI-Framingham be returned to their respective counties as soon as possible, with the goal of housing them in local jurisdictions near the courts in which they will be tried. Simultaneous efforts should be made to integrate county-sentenced females into lower security facilities. In order to accomplish this, each county should thoroughly assess its ability to house its own female offender population and explore establishing regional facilities. We also think that the construction of the proposed stand-alone, 200 bed facility for female inmates in Western Massachusetts is essential and will help assure the implementation of this recommendation. We urge the Legislature to appropriate sufficient funds for full and prompt completion of this facility, long recommended by Sheriff Ashe and his Western Massachusetts correctional/enforcement colleagues.

[5] Dedicated External Female Offender Review, Report from Subgroup A (August 1, 2005) p. 9

Recommendation #2 (female offenders): ***Women Should Not Be Civilly Committed to MCI-Framingham***

Over the past few years, there has been a drastic reduction in community based, publicly funded detoxification centers for women. As funding for detoxification centers and the Department of Public Health's programs to serve women has been cut, the use of the civil commitment statute, M.G.L. Chapter 123, Section 35, to deal with female substance abusers has expanded. As a result, an increasing number of women are being civilly committed to MCI-Framingham for inpatient care. Over the past eight years, the number of civil commitments to the facility has risen dramatically from five in fiscal year 1998 to 157 in fiscal year 2005.[6]

MCI-Framingham is not only accommodating a greater number of civil commitments, it is housing them for longer periods of time. After being sent to MCI-Framingham, civilly committed women are moved as quickly as possible to beds, located by a DPH contractor, in community based programs. Previously the average wait for a bed in one of those programs was 24-48 hours, but, in the past six months, the average wait has increased to 14-16 days.[7] This has also contributed to overcrowding.

Removing civilly committed females from MCI-Framingham will decrease overcrowding and will also help to insure that women receive inpatient substance abuse treatment in accordance with the expectations of the courts and their families. The Panel found that MCI-Framingham is not designed, equipped or staffed to serve as an acute treatment facility for substance abusers.[8] Under Section 35, civil commitments at MCI-Framingham must be housed and treated separately from convicted criminals. Consequently, women who are civilly committed with no additional criminal charge are not able to participate in the DOC's "First Step" substance abuse program because it includes sentenced inmates. Their opportunities for program participation are further limited because they are at MCI-Framingham for a relatively short time (30 days or less). As a result, the Panel determined that more than half the women civilly committed to MCI-Framingham in 2004 did not receive any substance abuse services.[9]

The Advisory Council suggests that a multi-agency task force be created, or linked with existing efforts such as the Governor's Inter-Agency Council on Substance Abuse and Prevention to address the lack of appropriate services for civilly committed women in the Commonwealth. This task force should include, at the very least, representatives from the Department of Public Health, the Department of Mental Health, the Department of Correction, the trial courts and the General Court. The Commonwealth should also fund detoxification centers throughout the state. From these centers, the Department of Public Health should offer community based services, including secure and non-secure beds that meet the substance abuse treatment needs of civilly committed women.

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[6] DOC Report on MCI Framingham, Section 35 Civil Commitments (August 1, 2005)
[7] Ibid.
[8] Dedicated External Female Offender Review, Report from Subgroup A (August 1, 2005) p. 17
[9] Ibid. p. 21

We also consider it to be the responsibility of judges and other court personnel to recognize and acknowledge the impact such sentences have on the inmate population. As noted earlier, the current trend towards increasing Section 35 sentences has led to serious conditions that should be recognized by the courts, including facility overcrowding and lack of programming and treatment. The Advisory Council believes it is critical to inform and educate relevant court personnel on the impact of civil commitments with emphasis placed on the repercussions of increased utilization.

Generally, the Advisory Council is of the opinion that providing women with appropriate program, treatment and reentry services at MCI-Framingham is inordinately difficult because, as the only maximum and medium security facility for women in Massachusetts, it is overcrowded, continues to experience an increase in its population each year, and houses women with complex and widely varied needs. The inclusion of pre-trial, county sentenced and civilly committed women contributes significantly to these challenges. More than two-thirds of the admissions at MCI-Framingham are awaiting trial or civil commitments, and of the remaining third, more than half are house of correction inmates. Therefore, we recommend that pre-trial, county sentenced and civilly committed women be removed from MCI-Framingham. This should allow the Department of Correction to focus more effectively on evaluating and implementing the Panel's remaining recommendations.

Health and Mental Health Services

The twenty-four members of the Medical Review Panel were divided into four sub-groups which considered the following specific issues: 1) the scope of medical, pharmacological, dental, and mental health services provided to inmates; 2) the gender-specific medical and mental health needs of the female population; 3) services provided at Bridgewater State Hospital and the Massachusetts Alcohol and Substance Abuse Center; and 4) services provided at Lemuel Shattuck Hospital.

The panel held its initial meeting on March 23, 2005 and during the ensuing five months the panel members reviewed numerous documents, toured correctional facilities, observed operations, reviewed medical records, and conducted focus groups with providers, inmates, correctional officers and DOC administrators. The groups submitted their findings and recommendations on September 16, 2005. They are set forth in detail in the enclosed Executive Summary and sub-group reports.[10]

Current Scope of the Department of Correction's Inmate Health Care Services

The DOC is charged with providing medical, mental health and dental care to approximately 10,000 inmates located in 17 state prisons throughout Massachusetts. It is

[10] The Council would like acknowledge the many members of the Dedicated External Health and Mental Health Review Panel who generously volunteered their time. We would also like to thank DOC Commissioner Kathleen Dennehy and members of her staff, especially Veronica Madden, Associate Commissioner of Re-Entry and Reintegration, who devoted innumerable hours to supporting the Panel's work.

also responsible for providing all health and forensic services at Bridgewater State Hospital, a prison which serves both state and county populations. In addition, the DOC provides detoxification and substance abuse treatment services to individuals who are civilly committed by the Courts pursuant to MGL Chapter 123, Section 35.[11] Finally, through an interagency service agreement with the Department of Public Health, the DOC utilizes Lemuel Shattuck Hospital for a wide range of inpatient, outpatient and surgical services.

Since 1992, the DOC has contracted for health care services through the public bid process. On January 1, 2003, University of Massachusetts Correctional Health ("UMCH") began providing services under the current four year contract. The total managed care contract for fiscal year 2005 is in excess of $56 million, which accounts for approximately 15% of DOC's total budget.

As a result, the DOC is now one of the state's largest institutional providers of mental health, health care, psychiatric, substance abuse, and long-term care services. In addition, DOC is faced with the challenge of providing these services to a remarkably diverse population in custodial settings, envorins and culture designed to ensure physical security as the top priority, not the provision of care or services.

The Advisory Council considers the provision of quality health and mental health services to be an essential responsibility of the Department of Correction, but we recognize that developing the medical expertise and capacity to deliver such multi-faceted care is outside the core mission of the DOC. So, particularly in the face of the drastically changing demographics of the inmates, the Department must rely on outside parties to deliver these services.

Of course this clearly does not relieve the Department of all responsibility. Some of the burden of improving medical services can only be assumed by the DOC. For example, the Department must be responsible for determining what its inmates' long-range health care needs are likely to be and planning accordingly. To improve medical care, the DOC must also ensure that contracts with its providers explicitly detail the agreed upon responsibilities, scope of medical services, standards of care, and quality measures, and have the capacity and will to manage the contracts and hold the vendors accountable. Finally, only the Department can make certain that its facilities, staffing, policies and procedures support quality care.

Still, many of the obstacles to improving the quality of medical care in the DOC need to be addressed by the Department in partnership with others. For example, other state agencies, the trial courts and community care providers must work together with DOC to address issues such as the increasing number of Section 35 commitments, inappropriate admissions to Bridgewater State Hospital, the aging demographics of inmates, and the lack of coordinated support for reentry.

[11] Civilly committed males are sent to the Massachusetts Alcohol and Substance Abuse Center (MASAC), and civilly committed females are sent to MCI-Framingham.

The Advisory Council has reviewed the Medical Task Force reports (attached) and found them to be thoughtful, reality-based and comprehensive. They contain fifty-eight major recommendations, which the Council considers to be generally well supported. Based upon the major issues identified in the Task Force reports, and the considerations noted above, the Council has concluded that seven recommendations are of the highest priority and should be urgently addressed. Therefore, the Council recommends that DOC and EOPS develop action plans and responses to the following:

RECOMMENDATION #1 (Health): ***The Department Should Determine What Its Health and Mental Health Care Needs Will be Over The Next Ten to Twenty-Years and Should Plan and Prioritize Accordingly***

As a result of external realities and sentencing practices beyond the control of DOC, the demographics on the inmate population are changing dramatically. The aging inmate population coupled with a significant increase in the number of inmates with serious chronic illness has created medical issues and operational problems that the DOC, Lemuel Shattuck and University of Massachusetts Correctional Health did not anticipate and are not prepared to handle. A comprehensive demographic and epidemiological study that attempts to project the DOC's long-term health care needs should be undertaken immediately.

RECOMMENDATION #2 (health): ***Contracts Between the DOC and Health and Mental Health Providers Must Explicitly State the Scope of Medical Services, Standards of Care, and Quality Measures.***

To improve the quality of medical care, the DOC's health services contract must be a comprehensive document that realistically outlines the scope of medical services, standards of care, and quality measures that can be effectively monitored and manged. This will ensure system-wide standardization of care and accountability. According to the Task Force, the current contract does not meet these criteria. Future contracts should specify minimum standards in at least the following areas: scope and levels of service, evaluation requirements, staff training, data collection requirements, contract review and compliance, and grievance procedures. Also, the contract's performance measures should be geared towards examining and evaluating the quality of the services provided, rather than be a compilation or report on quantitative data.

RECOMMENDATION #3 (health): ***The Department Should Adopt a Plan to Improve Health and Mental Health Services, Including a Review of Relevant Policies and Procedures; Staffing, Education and Training; Facilities and Infirmaries; and Technology and Equipment***

Specific conditions within the Department were identified by the Task Force as significant impediments to the delivery of quality health and mental health services. The Advisory Council recognizes that many of these conditions are the result of, or required by, budgetary or security constraints. However, we recommend that the DOC review and,

wherever possible, plan to remedy the internal impediments to the provision of medical care which were identified by the Task Force giving priority to the following:

A. Policies and Procedures

According to the Medical Task Force, the Department could improve the quality of its medical services by revising some of its policies and procedures. For example, the Task Force observed that inmate medication lines are long, managed inefficiently, and over-the-counter medications are frequently difficult to obtain in a timely fashion. The "sick call" process was also found to be inefficient with long waiting periods between submission of a sick slip and medical access, review, and treatment.

A multidisciplinary team of health care, treatment, security and other relevant staff should be charged with the specific task of reviewing and revising medical policies and procedures within each institution, including those related to dispensing medications, response to sick slip requests, transportation, and recommending practical, common sense changes, such as those recommended by the Task Force.

B. Staffing, Education and Training

The Medical Task Force noted that current staffing patterns at the Department are out-dated and based on prior conditions which have since changed. Today's 10,000 plus DOC inmate population is older, sicker and more psychiatrically compromised, increasing the overall drain on services across disciplines. Staffing patterns also negatively impact the ability of inmates with more serious medical and mental health needs to be classified to lower security facilities.

The staff, including medical, mental health and correctional personnel, currently lacks necessary specialized training to meet these far more complex and changing health and mental health care patterns. Specifically, the correctional officers who are in most frequent contact with the inmates simply lack sufficient training in medical and mental health issues.

Inmate education in health care issues is also lacking. In interviews conducted by the Task Force, inmates criticized the quality of the communication from health care providers regarding test results, diagnoses, and treatment plans. Furthermore, the Task Force found that inmate health education materials are targeted to readers at a level several grades higher than the average inmate literacy level.

The Department should hire a consultant to evaluate its staffing matrix and patterns. The evaluation should include the Department's ability to meet medical and mental health needs of inmates in lower security. DOC should also review and revise staff education and training on health and mental health issues. Finally, it should seek to improve communication between inmates and providers regarding medical issues and ensure that health related reading materials are culturally and linguistically appropriate for the inmates.

C. Facilities and Infirmaries

The Department should review options for updating its health care facilities and infirmaries and relocating some health services. The Medical Task Force found that the DOC's health care facilities are old and in various states of disrepair, preventing efficient health care delivery. Inadequate facilities may also compromise staff and inmate security. For example, at Lemuel Shattuck, the principal hospital utilized by the DOC, there is no protective custody and an insufficient number of secure beds. These structure and site capacity issues are major obstacles to efficient, cost-effective, secure service delivery.

There should be an ongoing review of all health service facilities, with input from clinicians, facility management and staff, central administration, UMASS Correctional Health, and outside consultants, with the goal of prioritizing projects to increase medical space and improve conditions. The Department should consider the creation of infirmaries at all custody levels. Capacity should be developed for more short term rehabilitation, long-term care, assisted living and end of life services outside the current infirmaries. The Department should also consider adding protective custody cells and additional secure beds at Lemuel Shattuck Hospital. Additional funding is needed to support this work.

D. Technology and Equipment

In order to improve the quality of care, the Department needs a more efficient system for tracking and maintaining records, prescribing medications, communicating between facilities, and communicating between primary care providers and outside consultants. The Department also needs to replace its old and defective medical equipment. It currently lacks essential equipment across all areas of medical services, including medication carts for nurses, autoclaves in dental units, and ultrasound machines for pregnant women. The fact is that the current antiquated state of technology and equipment is costly in the short and long-term. Modernization is an essential component of quality and fiscal responsibility. However, there is currently no line in the DOC's budget allocation for medical technology and equipment purchases.

The Department should pursue technology that will allow it to electronically maintain medical records and prescribe medications. Clinicians and other staff should also have access to the internet. Technology for telemedicine should be expanded to all large facilities with policy and procedure changes that allow for full and effective utilization.

The DOC should conduct a review and needs assessment of medical equipment and supplies throughout the system. It should seek to eliminate any internal and external barriers to procuring a sufficient supply of up-to-date and fully operational equipment. The feasibility of establishing a line item in the DOC budget for the purchase of medical equipment and supplies should also be explored.

RECOMMENDATION #4 (health): ***The DOC Should Review its Mental Health Services and Develop a More Comprehensive, Integrated and Efficient Program***

The Task Force identified some issues that are specific to mental health services. The DOC's current mental health program is not sufficiently comprehensive or integrated. For example, the Task Force found that some male inmates are denied access to residential treatment because it is only available at one security level. Another problem is the lack of coordinated treatment for patients with multiple medical issues, such a mental health and substance abuse problems.

A more comprehensive, integrated and efficient means of serving the mental health needs of the inmate population should be developed, which could include more access to group treatments, coordinated substance abuse and mental health services (perhaps under one contract), better review of open mental health cases, improved communication between security staff and clinicians to ensure better access to care, and opportunity for residential treatment at each security level.

RECOMMENDATION #5 (health): ***The DOC Should Review its Policies and Practices Regarding Patients at Bridgewater State Hospital. An Oversight Committee Comprised of the DOC, Sheriffs and Relevant Court Personnel Should be Established to Review Alternatives to Commitment to Bridgewater State Hospital***

The Task Force found that a persistent problem is the large number of inappropriate admissions to Bridgewater State Hospital ("BSH") from county facilities and state prisons that lack options for alternative treatment. The DOC should review its policies, practices and treatment protocols for patients at BSH. It should seek to increase the number of mental health workers, clinicians and forensic evaluators, and negotiate to allow the Superintendent to staff the hospital with correctional officers who are trained and motivated to work in a psychiatric facility.

An oversight committee comprised of DOC, Sheriffs and relevant court personnel should be established to review commitments to BSH. That committee should explore alternatives to commitments to Bridgewater such as: increasing or restoring mental health services in county facilities, and establishing a separate treatment program (outside of BSH).

RECOMMENDATION #6 (health): ***An Oversight Committee Comprised of DOC, DPH, DMH and Court Personnel Should be Established to Review Section 35 Commitments***

Since 2002, there has been a dramatic increase in the number of men and women committed to MASAC and MCI-Framingham under MGL Chapter 123, Section 35. An oversight committee comprised of the DOC, the Department of Public Health, the Department of Mental Health, and relevant court personnel should be established, or linked with existing efforts like the Governor's Inter-Agency Council on Substance Abuse and Prevention, to review Section 35 commitments. Its responsibilities should

include: clarifying the criteria for such commitments; establishing a uniform Section 35 assessment protocol; and educating and training court personnel regarding criteria and alternative treatment resources. The committee should also consider whether responsibility for treating civil commitments and managing MASAC should be transferred to the Department of Public Health with clear lines of authority and accountability to that agency. Finally, the oversight committee should review the substance abuse services provided within the DOC to ensure that the treatment is licensed by DPH.

RECOMMENDATION #7 (health): ***The Department and UMCH Should Strengthen Plans for Reentry and After Care Medical and Mental Health Services***

With 97% of the current incarcerated population eventually returning to their communities, medical and mental health care is a crucial component of inmate reentry. Successful transition from care in the DOC to care in the community is crucial to successful reintegration in society. The health and behavior of former inmates critically impacts public health and safety. Currently centralized resources and coordinated support for aftercare plans that meet the medical and mental health needs of the inmates are severely limited.

More attention must be devoted to discharge planning. DOC and UMCH should review the reentry planning process to ensure it occurs smoothly and in an integrated fashion. They should also work with community health and mental health providers. Increased partnerships with community-based providers could enhance healthcare reentry programming in home communities and promote effective referrals.

The Advisory Council's recommendations warrant immediate attention by EOPS, the Commissioner and the Governor. Obviously the Advisory Council recognizes that the implementation of many of these recommendations will require additional funds and assistance from a variety of agencies and jurisdictions. However, Commissioner Dennehy will move swiftly to do the same kind of excellent, expedited feasibility assessment and implementation plan for all of them that the DOC did for the original 18 GCCR recommendations.

IV. IMPLEMENTATION OF THE GCCR'S RECOMMENDATIONS: PRIORITY AGENDA FOR ACTION

The GCCR made 18 recommendations intended to reduce re-offending while enhancing fiscal responsibility and accountability within the DOC. Our Preliminary Report noted significant progress in one year's time, but also detailed barriers to change that must be removed, and internal actions that must be taken, in order for the reform process to proceed effectively. While much internal and external work remains, we believe that action on the following items must occur with all deliberate speed. Absent these changes, we cannot state with any certainty that the DOC's reform efforts will succeed, nor that crime caused by returning inmates will decline in the Commonwealth. We call upon the Legislature, Governor, Secretary of Public Safety, Secretary of Health and Human Services, Courts, Sheriffs, District Attorneys, Chiefs of Police, local government officials, local service providers and others to make the reduction of recidivism a statewide priority. To this end, the following, at a minimum, must be accomplished:

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1. *Classification Reform*

The GCCR concluded in 2004 that the inmate population in Massachusetts was overclassified; that is, inmates are held at a higher security level than is necessary to preserve public safety.

Overclassification is a barrier to the reduction of recidivism and the successful reentry of prisoners, because prisoners held in maximum security prisons are not eligible for the same programs and rehabilitative services as those held in medium and minimum security facilities. Overclassification also wastes public resources, because it costs substantially more money to run a maximum security prison than a medium or minimum security prison due to the higher correctional officer/inmate ratios and higher costs of technology and security. Between 1994 and 2004, the percentage of Massachusetts inmates in minimum security facilities declined from 23% to 11%, and the percentage of inmates in maximum security facilities increased from 9% to 19%. These figures greatly exceed national averages, and the Department has yet to reverse the disturbing Massachusetts trend. In fact, since 2002, the Department has closed five medium and minimum facilities. There are presently over 290 inmates awaiting transfer from either a maximum to a medium security prison or from a medium to a minimum or pre-release center, but these transfers are stymied due to the lack of available beds. The Department must open more minimum security and pre-release facilities to allow for the successful "step down" of prisoners throughout the system. To accomplish this, the DOC should reopen lower security facilities, and if necessary convert or reconfigure higher security facilities to achieve the appropriate mix of institutional settings.

The Department has made some progress in evaluating its inmate classification policies, but much remains to be done. In 2002 the Department engaged a consultant from the National Institute of Correction (NIC) to evaluate the classification instrument used by the Department, and to recommend a new objective, point-based classification system. While the consultant's work is concluded and a pilot classification system has been developed, this new instrument has yet to be implemented department wide. Moreover, the Advisory Council has not seen the new instrument nor has it been briefed about changes that are contemplated. Both the delay and the lack of communication are regrettable. Moreover, even after the new classification system is fully implemented there will be a problem in dealing with overrides. Anecdotal evidence suggests that the Department's prior classification instrument was overridden (resulting in higher classification) on a subjective basis in approximately 50% of the cases. There is presently no plan in place by the Department to monitor compliance with any new classification system that is put in place by tracking electronically all overrides so that they can be monitored and kept at an acceptable level. The Department must also commit itself to periodic (e.g. every six or twelve months) *reclassification* of inmates to insure that changes in inmate status (e.g. successful completion of programs or therapy, successful elimination of personal barriers to rehabilitation, etc.) are reflected in the prisoner's housing assignment.

Finally, as noted in the GCCR report, the proper classification of prisoners and preparation for their reentry to society is limited by certain state sentencing laws and practices (to cite but one example, inmates convicted of certain crimes carrying a minimum-mandatory sentence are ineligible for either parole or work release before the minimum term of their sentence is completed). The Department has begun to eliminate some barriers to "step down" by revising internal policies, which previously led to automatically higher classifications for certain groups of inmates. While these administrative steps are laudable, much more can and should be done. The Department, and perhaps even more importantly EOPS, the Lt. Governor, and the Governor need to be strong and vocal advocates for comprehensive statewide sentencing reform.

2. Re-Allocation of the DOC Budget

The GCCR report strongly recommended the reallocation of existing DOC budget resources to promote public safety in a fiscally responsible manner. Specifically, staffing costs account for 73 percent of the DOC's total budget, while inmate programs comprise a mere 12 percent. Therefore, the fiscal management of the department is closely linked with labor management and the rising costs of labor. The GCCR found that between 1995 and 2003, staffing costs increased from$200 million to $312 million, a 56 percent increase. The high cost of staffing reflects a number of factors, including the fact that correction officers take off an average of 60 days per year, of which 52 are paid (including 18 sick days per officer per year). Sick leave usage costs the department $21 million per year. The GCCR concluded, and the Advisory Council strongly agrees, that the DOC must restrain these labor costs for fiscal management reasons, but also to free up resources to bolster and expand recidivism-reducing efforts.

The Advisory Council believes that reallocating existing resources would be an easier, and more responsible, task than to requesting additional funds through the state budget process. We acknowledge that there are no "excess" funds in the DOC budget to re-distribute. Moreover, since our preliminary report issued, the Legislature amazingly saw fit to reduce the DOC budget, and the department is now operating at a $12 million deficiency. The council was dismayed by this budget reduction particularly after we advocated for no budget reduction in our Preliminary Report and in a letter to the legislature.

After examining staffing expenditures, the GCCR report concluded that by reducing officer absenteeism, sick leave usage and overtime usage, the DOC could recoup resources and apply them to enhancing inmate re-entry and public safety. While these are difficult areas for the DOC to address, they are critically needed. In addition to the high sick leave usage, there were over 300 workers out on Industrial Accident leave at the time of the report. These workers not only get paid, but other employees are hired on an overtime basis to fill in for them.

According to the recent DOC Performance Measures report, sick leave usage by Correction Officers declined during FY05 resulting in an average sick leave usage of 16.7 days per year, down from an average of 17.6 days in FY04. Although this usage level remains quite high, we hope that this downward trend continues, and urge the DOC to continue aggressive efforts to bring sick time usage down. We are disappointed to see that overtime usage rose over the past year from $10.4 million in FY04 to over $13.6 million in FY05.[12] The DOC attributes the rise in these figures to an increase in retirees from 214 in 2004 to 260 thus far this year.[13]

Commissioner Dennehy has pointed out that any serious reform in the use of leave time by correction officers and supervisors will need to be addressed at the collective bargaining table during contract negotiations. Minor savings have been attained by increasing management's focus and attention on the problem and reducing the instances of employee abuse. The Department has also developed better means of gathering and reporting data from the institutions regarding overtime and leave usage.

The Council understands that stronger management techniques for reducing worker absenteeism and overtime usage is just one facet of a plan to effect significant cost reductions. In addition, management must make gains in the collective bargaining process. We have maintained that given the size of the DOC's overtime budget, seeking additional funding from the legislature as a means to fund the department's re-entry mission should be a last resort. However, in light of the most recent budget cut for the department and the lack of progress at the bargaining table, additional funding may be required to support the DOC's public safety priority.

3. *Re-entry Legislation*

[12] Department of Correction, May, 2005.
[13] Department of Correction, June 8, 2005.

The GCCR found that "[s]uccessful re-entry of prisoners back to the community is limited by state sentencing laws and practices, as well as DOC policies, which directly impact inmate classification, programming options, pre-release, and supervised release. The DOC will be unable to fully implement a comprehensive re-entry plan until these areas are revised."[14] The DOC has made progress in revising many of the internal policies that restricted effective programming, placement and step-down. State sentencing laws and practices, however, have not changed. Legislative action is required.

It is crucial to note that at the time of the GCCR report, 84% of the inmate population was restricted by law from participating in pre-release programming (i.e., work release, education release and pre-release centers).[15] These statutory restrictions on re-entry include:

- ***Mandatory minimum sentences.*** These statutes specifically prohibit work release or pre-release for the entire mandatory portion of the sentence. Mandatory minimum sentences are generally crimes of violence, firearms offenses, drug offenses, and driving under the influence offenses. There are 1,441 offenders in the DOC with a mandatory drug offense, representing 16% of the population.[16]
- ***Parole eligibility***. By law the Commissioner may permit inmates to participate in pre-release programs *if they are within 18 months of parole eligibility* (43% of DOC inmates were not within 18 months of parole eligibility in December, 2003).[17]
- ***Prohibited crimes.*** A law restricts inmates convicted of certain enumerated offenses, although within 18 months of parole eligibility, from participation in pre-release programs except upon recommendation of the superintendent.[18]
- ***Work release limits.*** Various laws permit work release during the mandatory term of the sentence, only in the custody of an officer, upon recommendation of a superintendent.[19]

Post-Release Supervision

Supervised release of DOC inmates, particularly those at high risk for re-offense after serving their sentence, is crucial from a public safety standpoint. Unfortunately, most inmates in Massachusetts receive no supervision in the community upon release from prison. Particularly troubling is the large number of inmates who waive their right to a parole hearing, choosing instead to serve out their full sentences in order to be released to the community without oversight.

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[14] GCCR report page 43.
[15] Massachusetts Department of Correction, *Policy and Statutory Restrictions Impact on Inmate Placement*, (Concord, MA: January 2004)
[16] Massachusetts Department of Correction, Research and Planning Division January 1, 2003 Inmate Statistics, (Concord, MA: 2004), p. 22.
[17] MGL c. 127, sec. 49, emphasis supplied.
[18] Ibid.
[19] See MGL c. 90, sec. 23, 24, 24G and 24L.

The GCCR report strongly recommended that offenders who get released do so with ongoing monitoring and supervision. It also urged the Legislature to consider *mandating* post-release supervision for those inmates who are *not* released under parole supervision, either because of the terms of their sentence, because they waive parole eligibility, or because they are denied parole. In any of these scenarios, public safety would be better protected if inmates were supervised for a designated period of time after their release. Since that report, the Administration, under the leadership of Lt. Governor Healy, has filed a bill regarding mandatory post-release supervision which is currently pending before the Legislature.

The Advisory Council strongly supports the concept of mandatory post release supervision, particularly for high risk offenders, and we urge the Legislature to act swiftly in this regard. In crafting a supervised release policy, the Council believes that targeted interventions to reduce criminal risk are essential – particularly those that are demonstrated by research to be effective in reducing recidivism. Monitoring and supervision alone are not enough to reduce recidivism and may only lead to further violations and returns to incarceration. Pure supervision and monitoring may be appropriate for a small group of offenders who are at the highest risk for re-offense and not amenable to treatment or interventions.

Sentencing Practices

In 2002, according to the Massachusetts Sentencing Commission, 47% of the offenders who received state sentences received a sentence with only a one day difference between the minimum and maximum sentence.[20] This common sentencing practice in effect precludes appropriate step-down, gradual re-entry, and parole supervision for suitable inmates. Judges should be educated about the unintended consequences of this type of sentence.

As the GCCR Report specified, there are numerous ways to reform existing laws to eliminate obstacles to "step-down" and programming and post-release supervision. ***We urge the Legislature, Governor, District Attorneys, Sheriffs, and advocacy groups to act swiftly to pass legislation to improve re-entry and expand supervised release of inmates. This can be accomplished without reducing the length of prison sentences.*** Improved re-entry will enhance public safety for Massachusetts citizens and reduce the rate of re-offense by returning inmates.

4. *Statewide Re-entry Plan*

While re-entry has become an important concept in corrections, it is not the exclusive responsibility of the prison system. Many other agencies and organizations at the state and local levels have equally significant roles and responsibilities. The Parole Board and Probation Department have crucial community supervision roles. Since a large percentage of inmates have substance abuse addictions and mental health problems, the

[20] State of Massachusetts, *Survey of Sentencing Practices, FY 2002*, (Boston, MA: Massachusetts Sentencing Commission, May 2003), p. 31.

Department of Public Health and the Department of Mental Health are necessary partners. The collaboration of the county Sheriffs is also needed to address problems such as overcrowding of female offenders at MCI- Framingham, and enhanced re-integration and re-entry of male and female state inmates back to local communities. The DAs, the courts, and the Legislature also have vital roles to play in supporting legislative reforms. As such, we believe there is urgent need for a statewide re-entry plan. The plan should define roles and responsibilities in the re-entry effort, and serve as a blueprint for all relevant agencies. Without such attention and coordination at the state level, we fear that re-entry will not be given the priority it deserves, nor will important collaborative efforts continue among agencies.

In addition to the coordination of state agencies, at the local level criminal justice, human service, and housing agencies along with faith-based organizations and potential employers, have critical roles to play in ensuring that an inmate's transition back to the community is successful. We hope that a statewide re-entry plan would provide examples of effective state-local collaborations, and encourage local communities to become meaningful partners in re-entry.

State and local players must join together to make reduction of recidivism a priority. While many state and local agencies have engaged in discussions about how to improve offender reentry, very little concrete change in terms of action and resources has been realized to date. As stated in our Preliminary Report, we believe there is currently a window of opportunity for reform. This important work cannot be left to the DOC alone.

5. *Independent Inspector General*

The GCCR report called for an independent investigative authority ("IG") "outside and fully independent of the Department," structured in a way that preserves the Department's ability and responsibility to investigate complaints and incidents of employee misconduct in the first instance. Since that time, the Legislature has had bills under consideration that could accomplish this goal, with or without amendments. While creating an effective IG is a complex undertaking, the Legislature should nonetheless act swiftly on this issue. Other jurisdictions have created an IG, and we can do the same. Leaders from various segments of government should unite to craft a strong bill. We urge the Legislature to move forward on an IG Bill, with the input of EOPS, the Commissioner of Correction , and the Advisory Council.

Subsequent events have reinforced the GCCR's conclusion that an independent inspector general would promote enforcement of the laws and policies that govern the Department's staff. Efforts to change the Department's culture, the implementation of new policies and other changes during the past two years have led to charges and counter-charges from within and outside the Department. This should be expected in any effort to bring reform to bear within the Department. Having an outside investigative authority would help separate valid concerns from rhetoric, would reinforce the Department where it is correct, and expose areas where any staff or official of the Department has engaged in wrongful or undesirable behavior.

One area of concern has been the relationship between the proposed inspector general and other law enforcement authorities, including the District Attorneys and Attorney General. The GCCR did not in any way urge a system that would detract from the ability of law enforcement officials to perform their duties and exercise their discretion when criminal activity occurs behind prison walls. To the extent that any proposal may be thought to affect prosecutorial powers, that issue should be resolved in the legislative process, in order to create an inspector general's office that will, in fact, serve as a resource for both the Department and prosecutors.

There is no doubt that creation of an inspector general's office is a complex task. It may even need adjustment after enactment. The difficulty of the task, however, should not be a reason for inaction on this important component of the GCCR's report.

6. *Culture Change Inside the DOC*

In our Preliminary Report, the Council stated that major resistance to the cultural changes recommended by the GCCR has come from the leadership of one labor union, MCOFU, representing DOC corrections officers. While acknowledging all of the dangers and difficulties that correction officers face, we urge the leaders of MCOFU to become meaningful partners in the reform effort as soon as possible. Since the report issued, labor relations have not improved, and if anything, have deteriorated even further. Recent media accounts describe harassment, threats and personal attacks on the Commissioner and members of her senior staff by union members. In a recent newspaper account about these personal attacks, the president of the union was quoted as saying, "She needs to grow up."[21]

We value the important service correction officers perform, and the key role they play in maintaining public safety. We also believe that recent unseemly, disruptive, and unacceptable conduct is perpetrated by a small but active minority of correction officers. However, their actions poison the culture of the DOC, and undermine the hard work of those officers who seek to professionally and responsibly perform their duties. Regrettably, the culture in a handful of institutions, most notably MCI-Concord, appears to be nothing less than toxic.

We believe that much of this acrimony stems from the GCCR's conclusion that one of the primary reasons for growth in the DOC budget (totaling nearly a half billion dollars), was the rising cost of labor over the past decade, which comprised 73% of the total DOC budget. The high cost of staffing reflected a number of factors, including the fact that correction officers used an average of 60 days off per year, of which 52 were paid (including nearly 18 sick days per year). The total cost to the Department for correction officer sick leave usage was approximately $21 million per year.

[21] "Prison Boss Claims She's Target of Union Harassment, Threats," Boston Herald, September 1, 2005.

In addition, the GCCR examined the existing labor contract and found that it was distinguished by weak management rights provisions, large salary increases of 70% - 77% since 1992 (Massachusetts' correctional officers are the third highest paid in the nation according to the Bureau of Labor Statistics),[22] [23]and generous sick leave provisions, including 5 *unsubstantiated* sick days per officer per year. Finally, the GCCR noted that the DOC's staff-to-inmate ratio was the second highest in the nation, which also contributes to high staffing costs.

The GCCR report shed the spotlight on this information, and recommended a number of specific steps to bring down the high costs of staffing both in the collective bargaining process and through stronger management techniques. MCOFU's leadership vehemently opposed the much-needed changes in management and fiscal responsibility, and focused its efforts on derailing legislation recommended in the GCCR report, and lobbying for the removal of Commissioner Dennehy. Regrettably, contract negotiations between MCOFU and state officials have come to a standstill, even though virtually all the other unions representing DOC employees have either signed new collective bargaining agreements, or have tentative agreements that are pending ratification.[24]

We reiterate the sentiments of our Preliminary Report that the Commissioner's response and that of top management seems appropriate. The best way to effect change and deal with resistance is to provide a consistent and credible direction from above, with clear and predictable consequences. We hope that the Commissioner will continue to have clear and unwavering support in her efforts from all quarters, including the Executive Office of Public Safety and the Governor's office. We urge the union membership to take a stand against the vitriol and unprofessional – even unlawful -- conduct that has now come to characterize the labor-management relationship. The leadership of the unions could add immeasurably to the progress that has been made, while remaining committed advocates for the interests of their members. We continue to hold out hope that integrity and professionalism will prevail, and that the union will become a meaningful partner in this effort as soon as possible.

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[22] The top state for correctional officers and jailers pay is New Jersey, followed by California and Massachusetts. Bureau of Labor Statistics Occupational Employment Statistics, *Occupational Employment and Wages 2002*, www.bls.gov .

[23] The GCCR found that the increases in correction officer salaries, as negotiated by management and state officials in the last four labor contracts, were significant compared to other wage earners in Massachusetts. Correction officers' salaries increased by between 70% and 77% since 1992, or between 29% and 36% adjusted for inflation. By comparison, all Massachusetts wage earners gained only 17.9% in their inflation-adjusted salaries over the same period. The salaries of U.S. citizens as a whole increased 10.7% in the same time frame.

[24] MCOFU's labor contract expired in December, 2003 but remains in effect due to an 'evergreen clause.'

V. THE FUTURE OF THE ADVISORY COUNCIL

On September 15, 2005, Governor Romney signed an order for an on-going Corrections Advisory Council through December, 2006. We commend the Governor and Secretary of Public Safety for recognizing the value of the Advisory Council and for taking swift action to ensure that the Council continues. After almost one year of experience with this effort, for which there was no clear blueprint, we wish to offer the following recommendations for the future Advisory Council.

We strongly support the concept of an on-going, independent Advisory Council on Corrections to advise the Commissioner, and to monitor and garner support for the reforms set forth in the GCCR Report. By "independent" we mean a Council that is -- and is considered by the public to be -- a credible, external voice on the status of the prison system. The primary allegiance and purpose of the Council should be promoting the reform agenda set forth in the GCCR report and ensuring that the dollars we spend on corrections are being utilized to maximize public safety. Massachusetts needs such a voice on corrections given the closed nature of the system, the need to evaluate the charges and counter-charges that inevitably accompany changes to the systems and culture, and the tremendous amount of public dollars that we spend on our prisons. We do have strong views on the composition, mission, function, and establishment of such a body.

An Advisory Council should be comprised of a limited number of professionals who have noted expertise in corrections, law enforcement, and inmate re-entry, in addition to representatives from relevant state agencies, such as DPH, DMH, Parole and Probation. The composition of the current Advisory Council could be enhanced by adding members with particular expertise in inmate medical and mental health issues, inmate re-entry in communities, and representatives from other key players in the criminal justice system, such as the courts, parole and probation. Active representation from both houses of the Legislature is also important. A larger membership risks becoming unwieldy and expansion beyond experienced professionals and officials risks diverting the Council into political issues that are best discussed in legislative and executive arenas. In addition, the next phase of an Advisory Council may move in the direction of more closely examining recommendations that are beyond the DOC's control. The Executive Office of Public Safety has begun to spearhead a number of efforts that would promote some of these recommendations. Therefore, we encourage close cooperation and regular communication between the Advisory Council and EOPS on the status of these efforts. Finally, we recommend that the Council be staffed by persons who are not affiliated with any particular state agency or organization.

To attract qualified and motivated Council members, the instrument creating the Council must assure that the Council will have a truly independent voice and a defined mission. If the Council's advice is filtered or altered it would not be worth creating, as it would simply reinforce positions already taken by the Department and Administration. Assuring Council members that they may give advice "come what may," will convince

potential members that their time and effort will be rewarded by an end product that the Department and Administration will receive and at least consider.[25]

The mission of a future Advisory Council should be:

- to provide advice to the Commissioner;
- to serve as an independent advocate for reforms relating to the GCCR's recommendations, including legislative and policy changes;
- to identify and highlight the need for action by agencies, organizations and parties outside the Department;
- to monitor and support the implementation of the recommendations of the GCCR report[26] and working groups working under its auspices;
- to convene needed working groups on specific areas of concern as they arise (such as the working groups on female prisoners and on health/mental health); and
- to identify any necessary additional recommendations.

The role of supporting the implementation of the recommendations is crucial. Most likely, this can best be accomplished through legislative and external advocacy and public awareness efforts. Moreover, by convening multi-agency meetings or task forces, the Council could help to remove existing barriers to reform. Given the Council's expertise and knowledge, the group may be uniquely-positioned to review, draft and/or propose legislation including that related to inmate re-entry, post-release supervision, and an Inspector General for Corrections.

[25] There have been proposals to establish an Advisory Council through legislation, and we see some potential pitfalls with this approach. The value of establishing the Council in this manner is that it would help ensure that it is viewed as a credible, external voice apart from the Administration and Department over time, and would help preserve the state's commitment to an outside Advisory Council, regardless of who is Governor or DOC Commissioner. The potential hazard, however, is if the Legislature expanded the membership of the Council beyond those members specifically mentioned herein. If the Council included individuals representing special interests or constituencies, the productivity, credibility and efficacy of the group would be minimal. In such case, we would be better served without a Council. The challenge with establishing the Council via Executive Order is ensuring that a Governor, Secretary and all other members of an Administration commit to keeping the Council independent both in practice and in appearance.

[26] We hope that the Council will utilize the periodic DOC Performance Measures Reports in monitoring implementation.

VI. Conclusion

The GCCR report set forth an extensive plan to enhance public safety by reducing the rate of re-offense among inmates who return to our communities. The eighteen recommendations of the report involve establishing a comprehensive re-entry focus, improving accountability for managers, staff, and inmates, ensuring fairness and consistency in policies and practices, and instituting fiscal discipline. All of the recommendations, which were intended to be instituted together, support the ultimate goals of enhancing public safety and fiscal responsibility.

In our Preliminary Report, we found that the DOC had made important strides in implementing many of the eighteen recommendations of the GCCR report that were within its control. We applaud the DOC for quickly providing the first Performance Measures Report which will serve as an important baseline from which to measure further progress. We hope and expect that the future Advisory Council will use these indicators, along with other information, including DOC recidivism reports, to monitor progress in implementation.

We have also highlighted a number of crucial recommendations contained in the reports of the Task Forces on Female Offenders and Medical and Mental Health Services. We commend all those who devoted their time and expertise to these efforts. These reports in their entirety warrant attention and consideration by the DOC and state policy-makers. We have adopted those recommendations that we consider to be essential first-steps on the path toward comprehensive reform in these complex areas. We hope that the future Advisory Council will monitor progress on these reforms, and ensure that the other recommendations contained in these reports are closely examined as well.

While we commend the progress that has been made, we cannot conclude without stating that important work remains. The DOC cannot accomplish the recommendations of the GCCR report without action by others, including the Executive Office of Public Safety, Legislature, Lt. Governor, Governor, local leaders, law enforcement officials and community-based service providers.

While there has been much talk on how to improve offender re-entry, there are many areas in which additional concrete action must be taken. There is currently a window of opportunity for serious reform to make our system more effective at reducing re-offense, and this important work requires commitment and collaboration at many levels. All we seem to lack is the will and sense of urgency we believe is warranted. Every time a murder, rape or violent assault is committed by a returning inmate, we must ask if it represents a lost opportunity to have done more to protect the public. The Commonwealth must take action to stop the cycling of offenders in and out of our prisons, in furtherance of both public safety and fiscal responsibility goals alike.

APPENDIX I. SUMMARY OF THE GCCR's RECCOMENDATIONS

The GCCR stated that its recommendations were intended to be instituted together, and mutually reinforce one another in the interests of public safety and fiscal accountability. The 18 recommendations are as follows:

1. The Department should revise its mission to include reducing the rate of re-offense by inmates released into the community.

2. The Department should adopt a performance management and accountability system to enhance agency performance, improve the culture, and utilize budget resources more effectively.

3. The Department's management capacity should be strengthened through the collective bargaining process and revisions to the internal rank structure.

4. There should be an external advisory board on corrections to monitor and oversee the Department. The board should work cooperatively with the Commissioner to develop concrete goals for the future of the Department.

5. The Department should take responsibility for bringing down staffing costs and reducing worker absenteeism.

6. The Department's budget should be more closely aligned with its mission and priorities to enhance public safety in a fiscally responsible manner.

7. The Commonwealth must view reducing the rate of re-offense by returning inmates as one of its highest public safety priorities.

8. The Department should adopt a comprehensive re-entry strategy including risk assessment, proven programs, "step-down," and supervised release.

9. The Department should hold inmates more accountable for participation in productive activities designed to reduce the likelihood that they will re-offend.

10. The Commonwealth and the Department should revise sentencing laws and DOC policies that create barriers to appropriate classification, programming, and "step-down."

11. The Commonwealth should establish a presumption that DOC inmates who are released are subject to ongoing monitoring and supervision.

12. There should be a dedicated external review of inmate health and mental health services.

13. There should be a dedicated external review of issues pertaining to female offenders in the Department's custody.

14. The Department should ensure that policies and procedures, including those related to inmate classification, discipline, and grievances, are transparent, well-communicated, have specified appeals processes, and are implemented by staff who are appropriately selected, trained and supervised.

15. The Department should ensure that policies and procedures are properly implemented through oversight and accountability systems, including an independent investigative authority, data management, and unit management.

16. The Department should conduct a system-wide facility review to ensure that its physical plant is consistent with the security needs of the staff and the inmate population, and the Department's mission.

17. The Department should adequately protect and care for inmates in protective custody.

18. The Department should increase the linguistic diversity and cultural competence of its workforce.